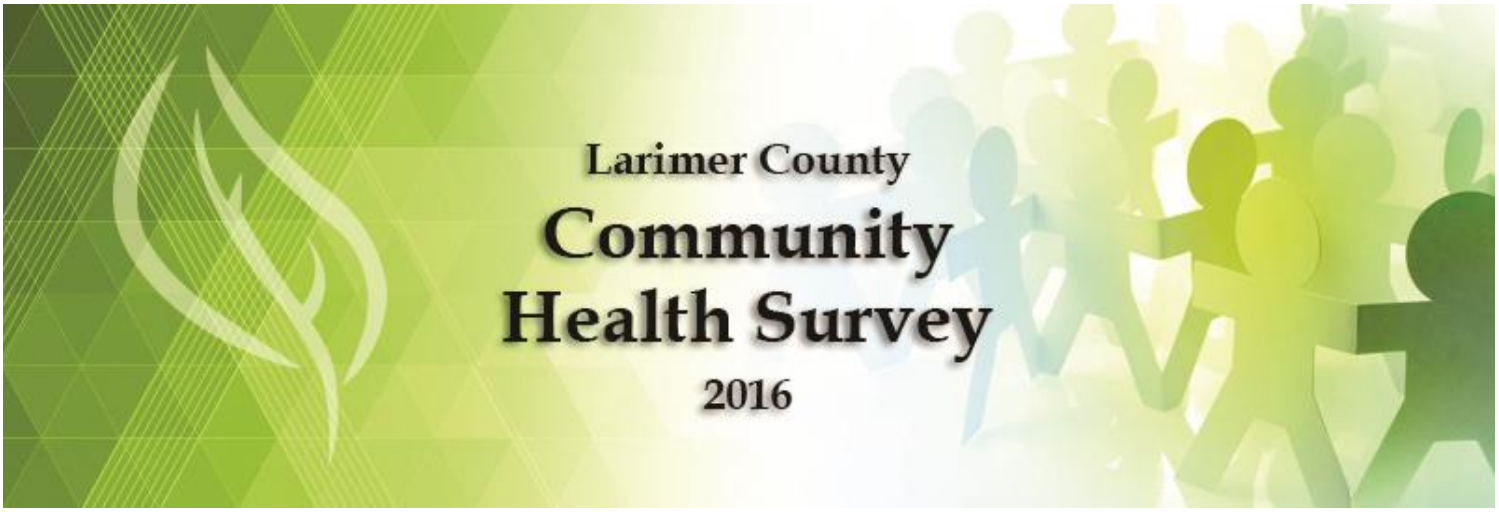

This survey is important.

We want to hear from you!

Your individual answers are kept confidential. Your responses will be grouped together with others to help us identify the health issues and concerns of Larimer County residents.

Your participation is voluntary. Thank you for completing this survey!

SURVEY INSTRUCTIONS

This survey should be filled out by the **adult 18 years or older** in your household **who will have the next birthday.**

Please complete the survey within the next 7 days to avoid additional mailings**.**

Please answer the questions only as they **apply to you.** You may be asked to skip questions. If you are not sure how to answer a question, please give the best answer and write any comment you wish next to the question.

Answer the questions with clear markings. Use an ✖ or ✓

Please make sure written comments are easy to read.

If you have questions or need assistance, call our survey help line at **970-224-5209**

or send an email to **survey@healthdistrict.org**.

Si desea llenar la encuesta en español, favor de llamar al 970-224-5209 para recibir una encuesta por correo ir al www.healthdistrict.org

WHERE YOU ACCESS HEALTH CARE

1. What is the <u>one type of place</u> you usually go when you are sick or need to see a medical professional?
(Mark an ✗ or ✓next to the <u>one place</u> you <u>usually</u> go.)

- ○ I do not have a regular place for health care.
- ○ A doctor's office, medical practice, or private clinic.
- ○ A community health clinic that offers a discounted fee.
- ○ An Emergency Room (hospital-based or freestanding).
- ○ An urgent care center or clinic that is inside a retail store.
- ○ A school, college, or university center or clinic.
- ○ Some other place. (Please describe):_____

2. In the <u>past 12 months</u>, how many <u>times</u> did you receive care in an Emergency Room? (*<u>if none</u>, please enter "0" and go to question 3)* _____ Number of times

2a. <u>If you received ER care in the past year</u>, think of the most recent visit. Was that <u>last visit</u> for a condition that you thought could have been treated by a regular doctor if he/she had been available?
○ Yes ○ No ○ Not sure

3. Is there a doctor, nurse, physician assistant or nurse practitioner that you consider to be your <u>regular</u> health-care provider? ○ Yes ○ No → *If no, go to question 6*

4. In the <u>past 12 months</u>, how many times did you receive care from your <u>regular</u> health-care provider?
(If none or not applicable, please enter "0".) _____ Number of times

5. Thinking about your <u>regular</u> health-care provider and where you get care from them, please rate the following:

	Excellent	Very good	Good	Fair	Poor	Very poor	I don't know
a. The length of time you wait between making an appointment and the visit.	○	○	○	○	○	○	○
b. The amount of time you have with your provider when at the office or clinic.	○	○	○	○	○	○	○
c. The ability to communicate with your provider by phone or email when needed.	○	○	○	○	○	○	○
d. Their attention to what you say.	○	○	○	○	○	○	○
e. Explaining things so you can understand.	○	○	○	○	○	○	○
f. How your provider talks with you about the pros and cons of each choice for treatment or health care.	○	○	○	○	○	○	○
g. How your provider or their staff talks with you about the cost of treatment or care.	○	○	○	○	○	○	○

6. Is there a particular dentist, dental hygienist, or dental practice that you consider to be your regular source of dental care? ○ Yes ○ No

7. Thinking of your health care, please rate:	Excellent	Very good	Good	Fair	Poor	Very poor	I don't know
a. Your access to health care whenever you need it.	○	○	○	○	○	○	○
b. Your ability to make an appointment with and see specialists if needed.	○	○	○	○	○	○	○

PREVENTIVE BEHAVIORS AND SCREENINGS

8. When was the last time you had the following? *(Mark ✗ or ✓ for one answer in each row.)*

	In the past year	Between 1 and 2 years ago	Between 2 and 3 years ago	Between 3 and 5 years ago	Between 5 and 10 years ago	10 years ago or longer	Never
a. Routine checkup by a doctor, nurse practitioner, or physician assistant (not for a specific illness, injury, or condition)	○	○	○	○	○	○	○
b. Dental exam and/or teeth cleaning	○	○	○	○	○	○	○
c. Blood pressure check	○	○	○	○	○	○	○
d. Blood cholesterol test (by drawing blood or pricking your finger)	○	○	○	○	○	○	○
e. Blood sugar test (diabetes screening)	○	○	○	○	○	○	○

9. When was the last time you had these cancer screenings?

	In the past year	Between 1 and 2 years ago	Between 2 and 3 years ago	Between 3 and 5 years ago	Between 5 and 10 years ago	10 years ago or longer	Never
a. Blood stool test using a home test kit (to test for colon cancer)	○	○	○	○	○	○	○
b. Sigmoidoscopy* or Colonoscopy* (a check of the rectum and colon for cancer)	○	○	○	○	○	○	○

Was your most recent exam a ○ Colonoscopy*? Or a ○ Sigmoidoscopy*? ○ I don't know ○ NA/ I never had one

***** *For a SIGMOIDOSCOPY, a flexible lighted tube is inserted into the rectum to look for problems. A COLONOSCOPY is similar, but uses a longer tube, and you are usually given medication through a needle in your arm to make you sleepy and you need someone else to drive you home after the test.*

c. <u>Men only</u>: Prostate specific antigen (PSA) blood test (to detect prostate cancer)	○	○	○	○	○	○	○
d. <u>Women Only:</u> Mammogram (a breast X-ray)	○	○	○	○	○	○	○
e. <u>Women Only:</u> Pap smear (a test for cervical cancer)?	○	○	○	○	○	○	○

<u>Women Only:</u> Please indicate if you've had a hysterectomy (an operation to remove the uterus or womb): ○Yes ○No

10. Did you get a seasonal flu shot or nasal mist during the last flu season (September 2015--April 2016)?

- ○ Yes
- ○ No
- ○ Not sure

11. In a typical 24-hour period, how many hours of sleep do you usually get? ☐ **Hours** ☐ **Minutes**

YOUR HEALTH CONDITIONS

	Excellent	Very good	Good	Fair	Poor
12. In general, would you say your health is:	○	○	○	○	○

13. Has a doctor, nurse, physician assistant, or other health professional ever told you that you had any of the following health conditions? *(Mark ✗ or ✓for yes or no answer for each item.)*

	Yes	No
a. High blood pressure (also called hypertension)	○	○
b. High cholesterol	○	○
c. Heart attack, coronary artery disease, or stroke	○	○
d. Cancer (malignant of all kinds, but not skin cancer)	○	○
e. Asthma	○	○
f. Chronic Obstructive Pulmonary Disease (COPD), emphysema, or chronic bronchitis	○	○
g. Diabetes (high blood sugar). *For women: If you were told you had diabetes only during pregnancy, answer "no."*	○	○
h. Arthritis or rheumatism	○	○
i. Depression	○	○
j. An anxiety disorder	○	○
k. Other mental health problem or mental illness (not depression or an anxiety disorder)	○	○
l. Alcohol or drug dependence	○	○

Other chronic disease (please specify):_____

14. Does a disability, handicap, or chronic disease keep you from participating fully in work, housework, or other daily activities? ○ Yes ○ No ○ I don't know

15. How many different prescription medications do you take or use at least once a week?
____ Number of prescription medications (*If none, please enter "0".)*

16. Do you now have any of the following conditions?	Yes	No
a. Depression, anxiety or other mental health problems	○	○
b. Toothache	○	○
c. Other problems with your teeth or gums	○	○
d. Asthma	○	○
e. Back problems or sciatica	○	○

17. In the past 12 months, have you considered suicide as a solution to your problems? ○ Yes ○ No

18. In the past 6 months:	Never	Some days	Most days	Every day
a. How often did you have pain?	○	○	○	○
b. How often did pain limit your life or work activities?	○	○	○	○

19. Please tell us a little more about your health during the past month:

a. How many days during the past 30 days was your **physical health** (including physical illness or injuries) **not good**?		(0-30 days)
b. During the past 30 days, how many days did **poor physical health** keep you from doing your usual activities, such as self-care, work, or recreation?		(0-30 days)
c. How many days during the past 30 days was your **mental health** (including stress, depression, or other emotional problems) **not good**?		(0-30 days)
d. During the past 30 days, how many days did **poor mental health** keep you from doing your usual activities, such as self-care, work, or recreation?		(0-30 days)

YOUR HEALTH HABITS

20. Not counting juice, on average, how many servings of fruit do you eat each day? *(A serving is ½ cup of chopped, cooked, canned, or frozen fruit, or one small (tennis ball size) piece of fruit or ¼ cup of dried fruit.)*

☐ Average number of servings per day *(If none, enter "0".)*

21. On average, how many servings of vegetables do you eat each day? (*A serving is ½ cup of chopped raw, cooked, canned, or frozen vegetables or one cup raw, leafy vegetables, or 4 ounces of 100% vegetable juice*.)

☐ Average number of servings per day *(If none, enter "0".)*

22. How often do you drink sugar-sweetened beverages? *These are drinks with added sugar, flavored syrups, or other sweeteners, such as regular soda pop, fruit punches or fruit drinks, sweetened or flavored tea, sweetened or flavored coffee drinks, sports drinks, energy drinks, and flavored or sweet milks. Do not include diet or sugar-free drinks or 100% juice.*

- ○ Never or rarely (weekly or monthly, but not every day)
- ○ Once per day
- ○ Two to three times per day
- ○ Four to five times per day
- ○ Six or more times per day

23. When you drink sugar-sweetened beverages, what is your typical serving size?

- ○ Small (about one cup, 8 ounces or less)
- ○ Medium (a can, small bottle, medium-sized soft drink cup, 9 –16 ounces)
- ○ Large (large bottle, super-size cup, more than 16 ounces)
- ○ Not applicable, I don't drink sugar-sweetened beverages

The next three questions are about alcoholic drinks. A drink is 1 bottle or 12 oz. can of beer, a 5 oz. glass of wine, or a drink with 1 shot of liquor.

24. Considering all types of alcoholic beverages, how many alcoholic drinks do you usually have in a week, including the weekend? ____ Usual number of drinks per week. *(If none, enter "0".)*

25. In the past 30 days, what is the largest number of alcoholic drinks you had on any single occasion?
____ Number of alcoholic drinks in one occasion. *(If none, enter "0".)*

26. In the past 30 days, how many times did you drive after drinking 2 or more alcoholic drinks in the hour before you drove? _____ Number of times you drove after having 2+ drinks. *(If none, enter "0".)*

27. How often do you do the following when driving a vehicle?

	Never	Rarely	Some-times	Almost always	Always	I don't drive
a. Make or receive phone calls?	○	○	○	○	○	○
b. Read or send text messages?	○	○	○	○	○	○
c. Read or send emails or update social media?	○	○	○	○	○	○
d. Use hands-free phone technology?	○	○	○	○	○	○

*These next three questions are about the **time you spent being physically active** in the last 7 days. This includes activities you do at work; as part of your house and yard work; to get from place to place; and in your spare time for recreation, exercise, or sport.*

28. During the last 7 days, how many days did you do vigorous physical activity that took hard physical effort and made you breathe much harder than normal, such as heavy lifting, digging, jogging, aerobics, or fast bicycling? Think only about those activities you did for at least 10 minutes at a time.

○ *Check here if no vigorous activity, then go to question 29.*

☐ Days per week → **How much time in total did you usually spend on one of those days doing vigorous physical activities?**

☐ Hours ☐ Minutes

29. During the last 7 days, how many days did you do moderate physical activity that made you breathe somewhat harder than normal, such as carrying light loads, bicycling at a regular pace, or gardening? Think only about those activities you did for at least 10 minutes at a time. Do not include walking.

○ *Check here if no moderate activity then go to question 30.*

☐ Days per week → **How much time in total did you usually spend on one of those days doing moderate physical activities?**

☐ Hours ☐ Minutes

30. During the last 7 days, how many days did you walk for at least 10 minutes at a time, such as walking at work or at home, traveling from place to place, or any other walking for recreation, sport, exercise, or leisure?

○ *Check here if no walking then go to question 31.*

☐ Days per week → **How much time in total did you usually spend walking on one of those days?**

☐ *Hours* ☐ *Minutes*

31. Do you now use any of the following tobacco/nicotine products?

	Yes, every day	Yes, some days	No
a. Cigarettes	○	○	○
b. Chew/spit tobacco or other smokeless products such as snus	○	○	○
c. Cigars, cigarillos, or pipes, including hookah	○	○	○
d. E-cigarettes, personal vaporizer, or other electronic nicotine delivery systems	○	○	○
e. Nicotine replacement products (such as patches, gum, or lozenges)	○	○	○

32. Which of the following best applies to you? *(Select one.)*

- ○ I have **never smoked** cigarettes (or smoked fewer than 100 cigarettes in my entire life).
- ○ I am a **former smoker** and have been smoke-free for less than six months.
- ○ I am a **former smoker** and have been smoke-free for longer than six months.
- ○ I am a **current smoker** and do not intend to stop smoking within the next six months.
- ○ I am a **current smoker** but thinking about quitting within the next six months.
- ○ I am a **current smoker** but seriously plan to quit smoking within the next 30 days.

33. Have you ever, even once, used marijuana (cannabis)?

○ Yes ○ No → *If no, go to question 34*

33a. If yes, have you used marijuana (cannabis) in the past 12 months for recreational or medicinal purposes?

○ Yes ○ No → *If no, go to question 34*

33b. If yes, thinking back over the past 12 months, about how many times did you use marijuana (cannabis)? _____ Number of times in past 12 months.

HEALTH INSURANCE

34. What type(s) of health insurance do you have currently? *(Mark ✗ or ✓ for all that apply.) Do not include insurance plans that cover only ONE type of service like dental, vision, or prescription drug plans.*

- ☐ I do not have health insurance of any kind. → *Go to question 34a.*
- ☐ Health insurance through current or former employer (including Cobra) or union including a partner's or parent's plan (including retiree benefit).
- ☐ Health insurance plan that I, my parents, partner or spouse purchase directly from an insurance company (privately or through Colorado's marketplace/exchange).
- ☐ Medicaid, also called Health First Colorado.
- ☐ Medicare (for persons 65 years and older or with certain disabilities).
- ☐ Veteran's Affairs, Military Health, TRICARE or CHAMPUS.
- ☐ Other (Please list): _____

34a. If you do not have health insurance currently, what are the reasons? *(Please explain.)*

35. Over the past 3 years, how many total months have you had no health insurance?

- ○ None (I've always had insurance).
- ○ A total of one month without insurance.
- ○ A total of 2 to 6 months without insurance.
- ○ A total of 7 to 12 months without insurance.
- ○ A total of 13 months or longer without insurance.

36. Do you currently have insurance that covers at least part of the cost for:

	Yes	No	I don't know
a. Prescription medicines?	○	○	○
b. Dental services?	○	○	○
c. Mental health services?	○	○	○
d. Vision services?	○	○	○

37. How worried are you that…	Very worried	Somewhat worried	Not too worried	Not worried at all	I don't Know
a. You won't be able to afford the medical care you need?	○	○	○	○	○
b. Health insurance will become so expensive, you can't afford it?	○	○	○	○	○

38. In the past 2 years, have you been unable to have a prescription filled because you could not afford it?

○ Yes ○ No

39. In the past 2 years, have you had any medical bills that you couldn't pay right away and had to pay over time? (This could include medical bills for any family member.) ○ Yes ○ No ○ I don't know

40. Thinking about your health care during the past 2 years, please answer the following:

	Yes, often	Yes, occasionally	No, never	Does not apply
a. Have you put off going to your health-care provider because visits are too expensive?	○	○	○	○
b. Have you put off going to a dentist because visits are too expensive?	○	○	○	○
c. Have you put off going to a mental health-care provider because visits are too expensive?	○	○	○	○
d. Have you put off a hearing test or purchasing a hearing aid because they are too expensive?	○	○	○	○

41. In the past 12 months, have you been contacted by a collection agency about owing money for medical bills? (This could include medical bills for any family member.) ○ Yes ○ No ○ I don't know

42. In the past 12 months, have you had to change your way of life significantly in order to pay medical bills? (This could include medical bills for any family member.) ○ Yes ○ No ○ I don't know

43. How often in the past 12 months were you worried or stressed about:

	Never	Rarely	Sometimes	Usually	Always
a. Having enough money to buy nutritious meals?	○	○	○	○	○
b. Paying your rent or mortgage?	○	○	○	○	○

ADVANCE CARE PLANNING

Advance care plans are official documents (also called directives) that describe your medical treatment wishes if you are ever too ill or injured to speak for yourself. Some of these advance care plans are the **Medical Durable Power of Attorney** that identifies the person you would like to make medical decisions for you, and a **Living Will,** that lists the types of medical treatments you want or do not want if you become terminally ill and are unable to make your own health-care decisions.

44. Have you completed an advance health care directive for yourself, such as a Living Will or a Medical Durable Power of Attorney?

O Yes O No → *If no, go to question 45.* O I don't know → *Go to question 45.*

44a. Have you ever had a serious discussion regarding your advance care directive, Living Will, or Medical Durable Power of Attorney with your family, friends, or other people you trust?

O Yes O No O I don't know

44b. Have you ever had a serious discussion regarding your advance care directive, Living Will, or Medical Durable Power of Attorney with a health-care provider? OYes ONo O I don't know

44c. Have you given a copy of your completed advance care directive, Living Will, or Medical Durable Power of Attorney to your health-care provider? OYes ONo O I don't know

ABOUT YOUR HOUSEHOLD

45. Including you, how many people (adults and children) live in your household?

☐ Number of adults age 18 and older
☐ Number of children age 17 or younger *(If none, enter "0" and go to question 46.)*

45b. If you have children under the age of 18, how many children do you have in each of these age ranges?

☐ Number of children under 5 years
☐ Number of children age 5 to 9
☐ Number of children age 10 to 14
☐ Number of children age 15 to 17

We are interested in children's health needs, too. **May we contact your household to complete a survey about your children?** O Yes ONo O NA, no children in my household

We know that people aren't used to talking about their income, but we ask these questions to get an OVERALL picture of our community, NOT to find out about you personally.

46. What was your household's total income before taxes in 2015? *Include income from all sources such as jobs, social security, public assistance, and retirement income for yourself and all other persons living in your household.* **If you are an undergraduate college student dependent on parental financial support, estimate your family's household income.**

O $12,000 or less	O $24,001 to $28,000	O $44,001 to $48,000	O $100,001 to $115,000
O $12,001 to $16,000	O $28,001 to $32,000	O $48,001 to $56,000	O $115,001 to $130,000
O $16,001 to $20,000	O $32,001 to $36,000	O $56,001 to $65,000	O $130,001 to $145,000
O $20,001 to $22,000	O $36,001 to $40,000	O $65,001 to $80,000	O $145,001 to $160,000
O $22,001 to $24,000	O $40,001 to $44,000	O $80,001 to $100,000	O $160,001 or more

47. How many people, including you, are supported by this income? _____ Number of people

48. Does anyone living in your household smoke cigarettes, cigars, or tobacco pipes inside your home?

O Yes O No O I don't know

49. In the past 12 months, did you or any member of your household need and/or use any of the community services listed below?	Did not need	Needed and used	Needed but did not use	I don't know
a. Mental health services such as counseling or treatment for adults	○	○	○	○
b. Services for children or youth with emotional problems or delinquent behavior	○	○	○	○
c. Alcohol/drug abuse services such as counseling or treatment	○	○	○	○
d. Low or no cost dental/oral health services	○	○	○	○
e. Home health care or homemaker services	○	○	○	○
f. Work-related or employment services (job training or help with finding work)	○	○	○	○
g. Financial assistance or welfare (unemployment, Colorado Works/TANF, social security disability/SSI)	○	○	○	○
h. Food or meal assistance (Food Bank, SNAP, Food Stamps, WIC)	○	○	○	○
i. Housing services (rental or purchase assistance, shelters, assistance with utilities, LEAP)	○	○	○	○
j. Transportation assistance services (vouchers, reimbursements)	○	○	○	○

INFORMATION ABOUT YOU

All of your responses will be kept completely confidential. We need this information for us to describe the health and well-being of the entire community. We will not be looking at or reporting your information individually.

50. What is your age? _____ years old

51. Are you? ○ Male ○ Female ○ Other
Women: Please ✗ *or* ✓ if you are pregnant: ○

52. Do you consider yourself to be?
- ○ Heterosexual (straight)
- ○ Homosexual (gay or lesbian)
- ○ Bisexual
- ○ Other

53. How much do you weigh in pounds (without shoes)? ☐ pounds

54. What is your height in feet and inches (without shoes)? ☐ feet ☐ inches

55. What is the highest level of education you have completed?
- ○ Less than 9th grade
- ○ 9th to 12th grade, no diploma
- ○ High school diploma or GED
- ○ Some college, no degree
- ○ Associate's degree (e.g., AA, AS)
- ○ Bachelor's degree (e.g., BA, AB, BS)
- ○ Graduate or professional degree

56. Are you a college student? ○ Yes, full-time ○ Yes, part-time ○ No *If no, go to question 57*

56b. If yes, are you a(n) ○ Undergraduate student ○ Graduate student

57. What is your current employment status? *(Mark all that apply with an ✗ or ✓.)*

- ☐ Employed full-time for wages
- ☐ Employed part-time for wages
- ☐ Self-employed
- ☐ Laid off or unemployed
- ☐ Disabled and unable to work
- ☐ Full-time homemaker
- ☐ Retired
- ☐ Military

58. Are you of Hispanic, Latino or Spanish origin? ○ **Yes** ○ **No**

59. What is your race? *(Mark all that apply)*

- ☐ White (Caucasian)
- ☐ Black, African American
- ☐ Native American or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Other: _____

60. Which of the following <u>best</u> describes your <u>current</u> marital status? *(Select one best answer.)*

- ○ Married
- ○ A member of an unmarried couple
- ○ Divorced or separated
- ○ Widowed
- ○ Never married

ABOUT YOUR COMMUNITY

61. Do you favor or oppose policies that would:	Strongly favor	Some-what favor	No opinion	Some-what oppose	Strongly oppose
a. Add extra taxes to soda pop and other sugar-sweetened beverages?	○	○	○	○	○
b. Require school districts to limit or restrict unhealthy food options for students during the school day?	○	○	○	○	○
c. Require schools to provide 3 or more days a week of physical education that includes vigorous activity?	○	○	○	○	○
d. Restrict the use of cell phones while driving?	○	○	○	○	○
e. Require retailers to have a license to sell tobacco products? *Currently, no license is required*.	○	○	○	○	○
f. Prohibit smoking in outdoor public areas such as restaurant patios, recreation areas or playgrounds?	○	○	○	○	○
g. Allow operation of marijuana retail stores and cultivation facilities?	○	○	○	○	○
h. Allow spraying mosquitoes to control West Nile virus if the local health department recommended it?	○	○	○	○	○

62. What is your level of agreement with the following statements about the <u>city, town, or rural area</u> where you live?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
a. It is easy to walk in my community.	○	○	○	○	○	○
b. It is easy to bike in my community.	○	○	○	○	○	○
c. It is possible for me to get to many places I need to go by biking or walking.	○	○	○	○	○	○

63. Do you read the *Health District Compass* newsletter that is mailed to homes in the Health District four times a year and is available on-line at www.healthdistrict.org?

- ○ Yes, I read most or all of the articles.
- ○ Yes, I read a few of the articles.
- ○ Yes, I skim the newsletter.
- ○ No, I never read it.
- ○ No, I never heard of it/I don't think I receive it.

COMMENTS AND FEEDBACK

64. What do you feel are the greatest local concerns or issues impacting the health of the people in Larimer County?

65. Do you have any suggestions about what the Health District of Northern Larimer County and other local organizations could do to have a greater impact on the health of the community?

Do you have any suggestions that could help us improve this questionnaire?

Thank you very much!

Please fold the survey and use the postage paid envelope to return it by mail.